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SCOPE FOR FINANCING OF HEALTH SERVICES IN UTTAR PRADESH

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I. ACHIEVEMENT OF THE STATE IN THE FIELD OF MEDICAL SERVICES

A well developed system of social services is extremely important for any economy since these services can offer a positive contribution towards the labour market prospects of the low income wage earners on one hand and enhance the productivity of those who either cultivate their own land or are self-employed in other activities. Good health and education both command a premium from employers in the labour market. On the other hand, the income of a worker is adversely affected if he withdraws from the workforce due to either illness or malnutrition. Besides this, good health, proper nutrition and educational achievements are not simply attributes which increase income of individuals and contribute positively towards economic growth, but are qualities desirable for the upliftment of both the individual as well as the society as a whole. It is on account of this that a positive association is observed between higher levels of health and education and the levels of living and the quality of life of the people. In this paper an effort is being made to look into the health services in Uttar Pradesh and to find out the scope of introducing a system of cost recovery of the health services provided by the state.

Soon after independence the country launched a very ambitious programme of setting up of Primary Health Centres (PHCs) despite the resource constraints as well as the dimension of the health problem in the country. Below the PHCs were the Sub-Health Centres. After 1985 the Community Health Centre (CHC) has also been introduced and this is above the PHC. The prescribed norms for health services and the existing situation in India and U.P. are indicated in Table 1.

Table 1 : Availability of Health Services and Prescribed Norms (As on 1.4.1990)

Type of Service	Prescribed Norm	India	U.P.
Doctor Population Ratio	1 : 3000	1 : 2299	1 : 4260
Bed Population Ratio	1 : 1000	1 : 1347	1 : 2593
Sub-Centre Rural Population Ratio	1 : 5000	1 : 4779	1 : 5533
PHC - Rural Population Ratio	1 : 30000	1 : 30394	1 : 37169
CHC - Rural Population Ratio	1 : 100000	1 : 335929	1 : 629977

Source : Health Information of India, Directorate of Health Services.

It is evident from Table 1 that the health services at the All-India level have been adequately developed and they are in accordance with the prescribed norms except with respect to CHC - Rural Population ratio. Uttar Pradesh, on the other hand, is lagging behind in each case. However,

improvement has been made since 1990 and the gaps between prescribed norms and actual attainment has been narrowed down considerably.

In order to provide health care various schemes have been initiated by the Central and State governments with the help of its own resources or those provide by international agencies. As a result considerable achievements have been made and they are adequately reflected if we look at some indicators of health. A brief picture of the same is provided in Table 2.

Table 2 : Some Basic Indicators of Health Care

State/ India		Birth Rate (Per '000)	Death Rate (Per '000)	Infant Mortality Rate (Per '000)	Life Expectancy (Years)
U.P.	1971	44.9	20.1	167	49.0
	1994	35.4	11.0	88	55.4*
India	1971	41.2	19.0	129	45.6
	1994	28.6	9.2	73	61.0**

N.B. : * Pertains to 1988-92 and ** Pertains to 1993.

Source : Health Information of India, Directorate of Health Services.

Table 2 clearly highlights the fact that between 1971 and 1994 considerable improvements took place both at the state and national level. The birth, death and infant mortality rates came down. As a result of these efforts the expectancy of life has gone up substantially.

Looking at the developments which have been taken place in the field of health infrastructure we find that the state has made a considerable achievement and the same can be seen in Table 3.

Table 3 : Health Infrastructure in Rural Areas of U.P.

Item	Base Year (1991-92)	Level at end of 1993-94	Likely achievement (1994-95)	Target (1995-96)
Sub-Centres	20153	20153	–	–
PHC	3625	3751	–	–
CHC	228	258	23	27
Hospitals/Dispensaries	4192	4375	118	100
(a) Allopathic	776	776	–	–
(b) Ayurvedic/Unani	2433	2533	78	100
(c) Homeopathic	983	1066	40	–
No. of Beds	28670	30126	986	1202
(a) Allopathic	21600	22716	674	802
(b) Atyurvedic/Unani	6452	6852	312	400
(c) Homeopathic	558	558	–	–

Source : Annual Plan, U.P., 1995-96, Vol.5, Government of U.P., State Planning Commission, April, 1995.

The health services in the rural areas of the state were being run with the help of 20153 sub-centres, 3652 PHCs and 228 CHCs in 1991-92. Besides this there were an additional 4122 hospitals and dispensaries as well. Most of these hospitals and dispensaries are Ayurvedic/Unani. By 1993-94 the number of these centres had registered an increase.

per the health norms the total requirement of the state was 23600 sub-centres, 3933 PHCs and 983 CHCs, which means that the level of attainment of sub-centres, PHCs and CHCs as compared to the norms laid down was approximately 85.4 per cent, 95.4 per cent and 26.2 per cent by the end of 1993-94. Only with respect to CHCs the attainment levels are low and this is primarily so because the concept of CHC was started in the year 1985. It is, therefore, obvious that the state has achieved a fair degree of success as per the required norms. It is true that the state is lagging behind the national average but before any critical appraisal is made on this account it must be realised that the size of the state both in terms of its area as well as population is vast and so the task of providing medical services all over the state equitably is a herculean one indeed. This problem has also to be visualised in the light of the fact that resource constraint has been a perpectual bottleneck and the limited resources at the disposal of the state have to be put to various alternative uses judiciously and in tune with the ongoing priorities.

We will, therefore, make an effort to see the pattern of expenditure which the state government made in the health sector over the different plan periods. The First Plan was a rather modest one and so only Rs.65.2 crore and Rs.4.70 crore were set aside by the Centre and State respectively for this sector. In percentage terms these worked out to be 3.3 and 2.6 per cent respectively of the total Plan outlays for the

Centre and State governments. In the case of U.P. Plan outlays went up steadily during the next two plans to touch an all time high of 7.62 per cent during the Third Plan. Since then, however, considerable fluctuations have been witnessed and the share of the health sector in the State went down to as low as 1.29 per cent during the Fifth Plan. In the case of the Central Government, on the other hand, there has been a gradual decline in the share of this sector and the same has come down from 3.3 per cent during the First Plan to 1.7 per cent by the Eighth Plan.

We may, therefore, sum up by saying that ever since the inception of the planning process in India the State government has been allocating funds for the provision of medical services. As a result, a fairly widespread medical infrastructure has been set up in the state and considering the size of the state as well as its total population, it has done reasonably well in the field of medical care.

II. LEVEL OF AVAILMENT OF MEDICAL SERVICES BY THE MASSES

So far the paper had focussed its attention on the development of the medical sector in the state. It is now time to see the extent to which these services are being availed by the people. For this we are utilizing the data provided by the NSS 42nd round. This National Sample Survey was mainly devoted to an enquiry on social consumption. In Table 4 information relating to distribution of hospitalised

cases over type of hospital is being shown. The Table highlights the fact that at the All India level around 55.5 per cent of the hospitalised cases in rural areas are treated in government hospitals and another 4 per cent in PHCs. The rest go to private hospitals and nursing homes, etc. In the case of the urban public nearly 59.5 per cent go to government hospitals while the rest get treated privately. As against this the percentage share of persons treated in government hospitals was lower both in rural (52.6 per cent) and urban areas (58.0 per cent) in the case of Uttar Pradesh. This, therefore, implies that a higher percentage of people, even in the rural areas of the state, are receiving private treatment in the case of hospitalization.

Table 4 : Percentage Distribution of Hospitalised Cases Over Type of Hospital

U.P./India	Public Hospitals	PHC	Private Hospitals	Charitable Instt.& Public Trusts	Nursing Homes	Others	Total
U.P.							
(a) Rural	52.61	2.76	27.26	3.46	10.10	3.81	100.00
(b) Urban	57.97	1.28	19.42	2.04	15.53	3.75	100.00
India							
(a) Rural	55.40	4.34	31.99	1.71	4.86	1.70	100.00
(b) Urban	59.51	0.75	29.55	1.91	7.04	1.24	100.00

Source : Sarvekshan, April-June, 1992.

The NSS report further points out that a very high percentage of patients hospitalised, in both rural and urban areas, opt for the free wards at the state as well as the All India level. In the rural areas this percentage is around 59 and 61 per cent for U.P. and India respectively whereas the corresponding percentages for urban areas are 56 and 55 per cent. However, despite the fact that a high percentage of people get admitted in non-paying wards in rural as well as urban areas, there are other medical expenses which have to be borne by them. Consequently, only a negligible percentage actually receive free medical treatment. Table 5 provides information in this connection.

Table 5 : Percentage Distribution of Hospitalised Cases Over Payment Categories

Items	U.P.	India
RURAL		
Payment Category :		
(a) No Payment	6.56	23.16
(b) Employer's Medical Welfare Scheme	4.82	6.18
(c) Reporting Payment to Institutions	88.61	70.66
(d) All	100.00	100.00
URBAN		
Payment Category :		
(a) No Payment	6.25	19.61
(b) Employer's Medical Welfare Scheme	11.62	12.95
(c) Reporting Payment to Institutions	82.13	67.44
(d) All	100.00	100.00

Source : Sarvekshan, April-June, 1992.

Table 5 reveals the fact that at the All-India level around 23 and 20 per cent of the hospitalised cases fall in the 'No Payment' category in rural and urban areas respectively. However, a completely different picture is presented in the case of Uttar Pradesh where only around 6 per cent of the hospitalised cases receive the benefit of 'No Payment.' The provision of Employer's Medical Welfare Scheme too is limited. Consequently around 88 and 82 per cent of the hospitalised cases have to make an expenditure on their hospitalisation in the rural and urban areas of the state. It will thus be worthwhile to find out what this burden of payment as a result of hospitalisation works out to in financial terms. This is presented in Table 6. As far as the rural areas of India as well as U.P. are concerned the average amount of money spent on hospitalisation is around Rs.300. However, private treatment is much costlier in the rural areas of the state. In the urban areas it is observed that the state average is much higher as compared to the All-

Table 6 : Average Payment Made in Hospitals in Rural and Urban Areas

State/ India	Rural			Urban		
	Govt.	Private	All	Govt.	Private	All
U.P.	299.48	972.06	648.73	683.50	1103.91	918.36
India	320.34	733.38	597.06	385.02	1206.01	933.33

Source : Sarvekshan, April-June, 1992.

India average in the case of government hospitals but the other way round when we look at average expenditure in private hospitals.

III. FINANCING OF MEDICAL SERVICES IN UTTAR PRADESH

Everywhere in the world the role of the state has been very important in assuring that health care becomes universally and equitably distributed as far as possible. However, this task has been very difficult in states such as Uttar Pradesh on account of limited resources, high growth rate of population and the very size of the state. In the case of many countries it is becoming increasingly difficult to run large systems of health facilities or heavily subsidised quasi-public systems. Some scholars argue that highly subsidised health care facilities, if not administered properly, are useless from the equity angle. In such situations they are generally enjoyed by the advantaged groups at the cost of the poor. It is, therefore, increasingly been felt that it is not possible for the government to increase the share of resources towards medical and health. Consequently, it is felt that the existing health financing policies in developing countries need to be reoriented.

In 1987 the World Bank recommended increased cost recovery for financing publically provided health services. It was pointed out chronic shortages of finance for drugs

etc. severely reduce the effectiveness of existing health services. The revenue received through increased cost recovery are proposed to be the means for improving quality, effectiveness and coverage of health systems.

The views of the World Bank regarding cost recovery has generated considerable debate. Some agree with the views and feel that some kind of cost recovery is essential considering the escalating cost of health services on one hand and the limited capacity of the government to finance these services on the other. Those in disagreement, express their fears on the ground that if user fees are increased in order to make cost recovery effective, the poor may not be in a position to afford medical services.

The way things stand it appears that in the year to come a shift might be essential in the health policy from the present system of subsidised health care to one where cost recovery is an integral part. This is so since health costs have been rising at a fairly rapid rate. Besides this the population too has grown at a reasonable pace thereby making it increasingly difficult for the government to raise budget allocations on medical and health to meet the actual requirements. Over and above these two factors, it must be accepted that there is an increasing pressure on us to do away with our system of subsidies if we are to become a part of the global economy. The path that we have adopted over the recent years assures that we are headed towards a free market economy and therefore time has come to introduce

changes in a phased manner in order to bring us in tune with other economies. However, any suggestion aimed at cost recovery should not imply that user fees should be raised without proper planning. While framing the policy the policy makers should take into account considerations of efficiency, equity and paying capacities of the masses along with the national objectives.

The emphasis on equity and paying capacity has a special significance in the case of developing countries since a high percentage of the population lives around or below the poverty line. So far the user fees, wherever they exist, are either very low or non-existent in the case of government run medical centres. In the restructuring of policy towards medical and health a range of policy options exist.

(a) One can think in terms of improving the pricing of services.

(b) A new approach to risk sharing through medical insurance can be adopted.

(c) The structure of subsidies on medical care can be altered.

(d) Efforts can be made to make optimal use of the existing medical infrastructure as well as optimal use of available resources for the medical sector.

(e) Maintaining a suitable balance between public - private mix.

In the case of our paper we will focus attention on the first two aspects. As will be seen these two, if handled properly, will be able to take care of the other three

(a) Pricing of Medical Services Through User Fees

It has already been pointed out that individuals are already paying for the health care services that are being availed by them and that even in the government run hospitals and other medical centres all treatment is not free. As a result even if a patient is admitted in a non-paying ward he has to incur other expenses. The figures had revealed that in Uttar Pradesh only around 6 per cent of the total hospitalised cases of rural as well as urban areas have been receiving treatment totally free of cost. Moreover, even in rural areas people go to the private clinics for treatment.

It is, therefore, very clear that people are quite willing to pay for medical care. Even in some government hospitals user fees are being charged in the form of a registration fee. In the rural health centres such fees are not being charged presently at the sub-centre, PHC and CHC level. A token registration fee can, therefore, be introduced. In the case of sub-centres the registration fee can be fixed at rupee one per registration. The same may be fixed at rupees two and three per registration in the case of a PHC and CHC respectively. In the district level hospitals, where a registration fee is already being charged, it can be suitably increased. However, during the first phase of cost recovery the ward fees and charges for pathological tests should not be enhanced or else the poorer sections will be adversely affected.

However, if user fees are to be introduced or enhanced, the authorities must simultaneously ensure that there is a qualitative improvement in the health services which are being provided. Unless this is ensured the people will not visit the government health centres and get themselves treated privately instead. Good quality medical services can be provided by ensuring that the medical centres are properly staffed and have adequate supply of medicines and other facilities. For this the efficiency of the centres will have to be improved through better management. Besides this, the amounts received by the centres through registration and other fees should be utilised by the concerned centre itself. This will promote decentralisation as well as local control and bring about quality improvement through staff involvement. The direct advantage of this will be that once these centres start functioning efficiently, patients will visit them willingly and consequently the unnecessary burden on district level and other hospitals, visualised presently, will be effectively reduced. At present people are by-passing the sub-centre, PHC and CHC as they are inefficient and ill-equipped. Once these desired changes are affected it will also strengthen the referral system.

Once the government decides on introducing the concept of cost recovery, the policy makers must take into account the questions of efficiency and equity along with the national objectives and also assure financial viability. Some of the factors to be kept in mind will be :

(a) A proper assessment of the cost of fee collection;

(b) Adherence to the principle of equity; and,

(c) Appropriate price fixation in tune with the paying capacity of the users.

(b) Medical Insurance

Promoting the concept of health insurance is relatively easy in urban as compared to the rural areas. In fact, some health insurance schemes already exist and a section of people have indicated their willingness in their favour by joining the schemes. The need is to simplify the procedure with a view to make them within easy reach of the common man. Initially the medical insurance scheme can be made compulsary for all government and quasi-government employees. Almost all government and quasi-government institutions are already deducting specified amounts towards group insurance of the employees. A similar deduction can be introduced towards their medical insurance as well. Along with the deductions a detailed programme should also be chalked out regarding the provision of efficient and timely medical treatment to the needy persons. Once this medical insurance scheme is worked out and properly implemented, it can be extended to the private sector as well.

In the case of the rural areas a much greater effort will be required for the promotion and successful implementation of the health insurance scheme. However, it can be worked out even for the rural households. One way to

initiate such a scheme can be by asking the rural development banks or other banks to deduct a small specified amount towards medical insurance from the crop loan or such other loans taken by the people for agricultural purposes. In exchange for this deduction they can be provided medical insurance cards which will guarantee them free treatment in specified health centres. Since all rural households do not take crop loans such a scheme will have only a limited coverage to begin with. But once such a beginning is made and a section of rural people start enjoying the benefits of the scheme, others will automatically be attracted towards it. Once such a stage has been reached, the Panchayats can be handed over the responsibility to collect the premium towards medical insurance from each household. This will ensure total coverage of the rural households.

Such an insurance scheme has a direct equity enhancing impact since such a scheme makes medical benefits available even to the poorest sections of the society. Normally the common man will hardly be in a position to afford expensive treatment from his own limited means. Here too, it must be very clear that premium rates should be fixed keeping in mind the paying capacity of the masses.

In this way financing of medical services can be done either by charging direct user fees in the government run hospitals or through a scheme of medical insurance or a combination of both. Since people have been paying for the

medical care it will not be very difficult to implement these schemes. However, people should be made fully aware of the schemes and the extent of medical benefits which they will receive under these scehems. Only if the confidence of the people has been gained and the rates of cost recovery and insurance premiums are worked out judiciously that the schemes will be successful in attaining their desired objectives.